Child's Name: _____ **DOB:** _____ **Date:** _____

ID#: _____ **Service Coordinator/Targeted Case Manager:**_____

Form C: Your Child's Service Coordination/Targeted Case Management Plan Page __ of Form C

An assessment has been completed to determine your child's medical, social, educational, environmental and/or other support services needed.

Date of Service Coordination/Targeted Case Management Assessment: _____

YOUR CHILD'S SERVICE COORDINATION/TARGETED CASE MANAGEMENT GOAL(S):

SERVICE COORDINATION/TARGETED CASE MANAGEMENT NEEDS: Your Service Coordinator will conduct the following steps to help you access services and supports beyond what Early Steps provides. This plan will be reviewed and revised as changes occur to your situation or circumstances but no less frequently than every six months.

Referrals/Activities/Linkages to be Completed by Service Coordinator/Targeted Case Manager	Date of Referral/ Activity	Agency/Individual to Whom Child/Family is Referred/Linked and Who is Responsible for Providing Assistance/Service/Support

☐ I participated in the development and/or update of this plan.

Parent/Guardian Signature: _____ Parent/Guardian Signature: _____ Date: _____

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_____ _____ _____

Service Coordinator/ Targeted Case Manager Signature Title Date

☐ I reviewed this plan and no changes are needed.

Parent/Guardian Signature: _____ Parent/Guardian Signature: _____ Date: _____

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_____ _____ _____

Service Coordinator/ Targeted Case Manager Signature Title Date